1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3337

03296

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Garrett Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Star Route 40
c. LENGTH OF STAY IN 1b Instant
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Frostburg
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Earl Middle Harvey Last Caton
4. DATE OF DEATH Month March Day 5 Year 1960
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 1-1939
9. AGE (In years last birthday) 21 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY Seabold Trucking
11. BIRTHPLACE (State or foreign country) Finzel Road
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Earl C. Caton
14. MOTHER'S MAIDEN NAME Nannie Allbright
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 202-34-1723
17. INFORMANT Address Mrs. Pearl Garlitz

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock — INTERVAL BETWEEN ONSET AND DEATH: 15 min
DUE TO (b) Hemothorax, Abdominal hemorrhage — 15 min
DUE TO (c) Ruptured Lung, right, Ruptured liver — 15 min

816X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of right arm

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto collision
20c. TIME OF INJURY Hour & Min. 9:00 p. m. Month, Day, Year Mar. 5 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #40
20f. (City or town) 6mi. W. of Frostburg (County) All. Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 3-5-60
EXAMINER'S NAME (Type) James H Jenster, Jr

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/9-60
22c. NAME OF CEMETERY OR CREMATORY Johnson
22d. LOCATION (City, town, or county) (State) Garrett Co.

23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst - Frostburg, Md. ADDRESS
24a. REC'D BY REGISTRAR DATE MAR 8 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03297

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with registror priar to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Liberty St. Ext.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Oakland
d. STREET ADDRESS: Liberty St. Ext
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: David — Middle: — Last: Collins

4. DATE OF DEATH: Month: 3 — Day: 8 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): stone mason

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Fairchance, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Collins

14. MOTHER'S MAIDEN NAME: Sarah Bosley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 214-32-3060

17. INFORMANT: Priscilla Shaffer — Address: Oakland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
DUE TO (b): Arteriosclerosis, generalized — years.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3-9-60

EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 3/10/60

22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery

22d. LOCATION (City, town, or county) (State): Oakland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Minnich Funeral Home Oakland, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Mauld

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3338 03298

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Swanton
c. LENGTH OF STAY IN 1b: 55 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ----

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Swanton
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beatrice — Middle: L. — Last: McRobie Custer

4. DATE OF DEATH: Month: March — Day: 24, — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 27, 1899

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. McRobie

14. MOTHER'S MAIDEN NAME: Stella Rodeheaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-36-9411

17. INFORMANT: Ray R. Custer — Address: Swanton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction, Acute — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feaster, Jr. M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D. — 3-25-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/27/1960

22c. NAME OF CEMETERY OR CREMATORY: North Glade Cemetery

22d. LOCATION (City, town, or county) (State): near Swanton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. L. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR DATE: MAR 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3331

CERTIFICATE OF DEATH

03299

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND, MARYLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. VA. — b. COUNTY: TUCKER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DAVIS, 85X-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First AGNES — Middle BELL — Last EVANS

4. DATE OF DEATH: Month MARCH — Day 6 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 16, 1894

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MAYSVILLE, W. VA.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOE MC GRAW

14. MOTHER'S MAIDEN NAME: PEARL EVERLY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Homer Evans — Address: Davis, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b): Tabarchie, Panenchymal, Secondary, — 2 mos
DUE TO (c): to a.

199.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November, 1952, to March 6, 1960, that I last saw the deceased alive on March 6, 1960, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred Cwre Jr. M.D.
ADDRESS (Street, city or town, state): AURORA, W. VA.
DATE SIGNED: March 8, 1960

PHYSICIAN'S NAME (Type): DR. ALFRED CWRE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/60
22c. NAME OF CEMETERY OR CREMATORY: Davis
22d. LOCATION (City, town, or county) (State): Davis, W.Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Wayne C. Wiggle
ADDRESS: Davis, W.VA.

24a. REC'D BY REGISTRAR DATE: MAR 10 '60
24b. REGISTRAR'S SIGNATURE: Anthony S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Item 23 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3339 **CERTIFICATE OF DEATH** 03300

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Garrett MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville
c. LENGTH OF STAY IN 1b all life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Friendsville Md.
d. STREET ADDRESS R.F.D. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MATIN Middle - Last -FALKNER
4. DATE OF DEATH Month Mar Day 17 Year 1960
5. SEX M. 6. COLOR OR RACE W. 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH ~~Feb~~ 14 1882 ~~1960~~
9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Jud.
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Nva
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Samuel Faekner
14. MOTHER'S MAIDEN NAME Martha Friend

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 236-01-9285
17. INFORMANT Address Mrs Martin Faekner - Friendsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary Arteriosclerosis

DUE TO (c) Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of Prostate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1959, to Dec, 1959, that I last saw the deceased alive on Dec, 1959, and that death occurred at 1205 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Pedro Riviera M.D. ADDRESS (Street, city or town, state) Friendsville, MD DATE SIGNED Mar 13-60

PHYSICIAN'S NAME (Type) PEDRO RIVERA

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Mar 15 1960
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cem
22d. LOCATION (City, town, or county) Friendsville (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE H H Rodaheaver ADDRESS Markleysburg Pa
24a. REC'D BY REGISTRAR DATE MAR 17 '60
24b. REGISTRAR'S SIGNATURE Arthur L Knous

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Item 23 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3349

Reg. Dist. No. 03301

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Lake Park, Md.
c. LENGTH OF STAY IN 1b: Minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: WEST VIRGINIA b. COUNTY: PRESTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EGLON
d. STREET ADDRESS: 85X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle T. Last FIKE

4. DATE OF DEATH: Month MARCH Day 11 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUGUST 15, 1900

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman & Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Electrical Supplies

11. BIRTHPLACE (State or foreign country): EGLON, WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JONAS FIKE

14. MOTHER'S MAIDEN NAME: DELLA HAMSTEADZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 233-16-9485

17. INFORMANT: Address: J. ROGER FIKE, OAKLAND, MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CORONARY SCLEROSIS — ****
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feaster, Jr. M.D. — DATE SIGNED

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James H. Feaster, Jr., M. D. — 3-11-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial
22b. DATE THEREOF: 3/14/60
22c. NAME OF CEMETERY OR CREMATORY: Eglon Cemetery
22d. LOCATION (City, town, or county) (State): Eglon, West Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: P. R. Watson
ADDRESS: Terra Alta, W.Va.
P.R.WATSON, F.D. LICENSE A 7220

24a. REC'D BY REGISTRAR DATE: MAR 16 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03302

3341

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville
c. LENGTH OF STAY IN 1b: Most of Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Friendsville Md
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Friend — Last: Frazee

4. DATE OF DEATH: Month: Mar — Day: 18 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Sept 4-1873

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Scott Friend

14. MOTHER'S MAIDEN NAME: Ellen Laughery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Agnes Frazee — Address: Friendsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory Failure — INTERVAL BETWEEN ONSET AND DEATH

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c): Old Age

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 19 59 to March 1960, that I last saw the deceased alive on March, 1960, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Pedro Rivera M.D.

ADDRESS (Street, city or town, state): Friendsville, Md

DATE SIGNED: Mar 1960

PHYSICIAN'S NAME (Type): PEDRO RIVERA

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar 21-1960

22c. NAME OF CEMETERY OR CREMATORY: Addison Cemetery

22d. LOCATION (City, town, or county) (State): Addison Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: M.S. Rodabaugh — ADDRESS: Markleysburg Pa

24a. REC'D BY REGISTRAR DATE: MAR 28 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

PEDRO RIVERA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3342

CERTIFICATE OF DEATH

03303

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Friendsville Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Friendsville Md
d. STREET ADDRESS: R.F.D. 2
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First HAROLD — Middle DAVID — Last FRIEND

4. DATE OF DEATH: Month MAR. — Day 1 — Year 1960

5. SEX: M.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 26 — 1889

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: agriculture

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: David H. Friend

14. MOTHER'S MAIDEN NAME: Mary Gary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): none
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 214-24-2274

17. INFORMANT: Mrs Ruth Friend — Address: R.F.D 2 Friendsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left Ventricular Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b): Arterioscleratic Heart Disease
DUE TO
(c):

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1958, to Feb 29, 1960, that I last saw the deceased alive on 2-29-, 1960, and that death occurred at 8:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Pedro Rivera M.D.
ADDRESS (Street, city or town, state): Friendsville, Md
DATE SIGNED: Mar-2-1960

PHYSICIAN'S NAME (Type): PEDRO RIVERA

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 3-60
22c. NAME OF CEMETERY OR CREMATORY: Sand Spring.
22d. LOCATION (City, town, or county): Friendsville (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: W St Rodaheaver — ADDRESS: Markleysburg Pa

24a. REC'D BY REGISTRAR DATE: MAR 7 '60

24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

GARRETT Md GARRETT

Md Friendsville Rural

RFD 1 Friendsville Md

HAROLD - DAVID - FRIEND MAR. - 1 - 60

M. White Feb-26-1887 71

U.S. FARMER agriculture Md

David H. Friend Mary Harp

None None 2-24-22 Mrs Bertha Friend - Friendsville, Md RFD 2

[illegible] Friendsville

[illegible]

Sept [illegible] 1958 1-1-60

Mar. 1960 Friendsville, Md

[illegible]

Burial Mar 3-60 Sand Spring Friendsville Md

H.W. Bittinger - McHenry Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03304

3332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b: 54 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oak Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Oakland,
d. STREET ADDRESS: Oak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: — Last: Gemmell

4. DATE OF DEATH: Month: March — Day: 10, — Year: 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 26, 1886

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Florist

10b. KIND OF BUSINESS OR INDUSTRY: Green House

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (First name not known) Gemmell

14. MOTHER'S MAIDEN NAME: Katherine Huthhinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-7707

17. INFORMANT: Teresa Welling — Address: Oakland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150X
(b): Primary Carcinoma of Esophagus — Unknown

DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 20 19 59, to March 10, 1960, that I last saw the deceased alive on March 6, 1960, and that death occurred at 1:15P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert H. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St. Oakland Md. — DATE SIGNED: 11 Mar 60

PHYSICIAN'S NAME (Type): Herbert H. Leighton, M. D. — Oakland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/13/1960

22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery

22d. LOCATION (City, town, or county) (State): Oakland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 14 60

24b. REGISTRAR'S SIGNATURE: Esther L. Friend

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3343 — Reg. Dist. No. — 03305

1 PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE, MD
c. LENGTH OF STAY IN 1b: 20 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE, MD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVE — Middle: DORTHEA — Last: HOOVER

4. DATE OF DEATH: Month: MAR. — Day: 27 — Year: 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 8 1908

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TELEPHONE OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: SPRINGS MUTUAL

11. BIRTHPLACE (State or foreign country): CONNELLSVILLE, PA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE YOMMER

14. MOTHER'S MAIDEN NAME: IDA BITTINGER.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-23-9691

17. INFORMANT: Mrs. Hoover — Address: 9203 Orbiter Rd, Balt, 14 MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James N. Fenter, Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-27-60

EXAMINER'S NAME (Type): JAMES N FENTER, JR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/31/60
22c. NAME OF CEMETERY OR CREMATORY: GRANTSVILLE
22d. LOCATION (City, town, or county) (State): GRANTSVILLE GARRETT Co MD

23. FUNERAL DIRECTOR'S SIGNATURE: Don Newman — ADDRESS: Grantsville, Md

24a. REC'D BY REGISTRAR DATE: APR 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur E. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03306

3333

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ROUTE # 2 DEER PARK
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle E. — Last KISNER

4. DATE OF DEATH: Month MARCH — Day 11 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 22, 1888
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JACOB KISNER
14. MOTHER'S MAIDEN NAME: JAMIMA ENLOW

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-01-4891
17. INFORMANT: CHARLES E. KISNER — Address ROUTE # 2 DEER PARK, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis, Generalized — 4 years
DUE TO
(c):

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-26, 1960, to 3-11, 1960, that I last saw the deceased alive on 3-10, 1960, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Feaster Jr. M.D. — ADDRESS (Street, city or town, state): 58 2nd St Oak. Md. — DATE SIGNED: 3-11-60

PHYSICIAN'S NAME (Type): DR. JAMES H. FEASTER JR. — OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/13/1960
22c. NAME OF CEMETERY OR CREMATORY: Nethken Hill Cemetery
22d. LOCATION (City, town, or county) (State): Elk Garden, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03307

3344

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

094

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1. **PLACE OF DEATH**
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL GRANTSVILLE
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): GOODWILL MENNONITE HOME, GRANTSVILLE, MD

2. **USUAL RESIDENCE** (Where deceased lived. If institution, residence before admission)
a. STATE: MD
b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL GRANTSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ELIZABETH Middle Last KLOTZ

4. **DATE OF DEATH**: Month MAR Day 2 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 23, 1869

9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY: BROTHERS Home

11. BIRTHPLACE (State or foreign country): BITTINGER GARRETT Co MD

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CHRIST KLOTZ

14. MOTHER'S MAIDEN NAME: MARY POPE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

INFORMANT: Mr. Lewis Klotz Grantsville, Md Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
(b): Generalized arteriosclerosis — 20 years
DUE TO
(c):

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from Feb 1, 1960, to March 2, 1960 that I last saw the deceased alive on March 1, 1960, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. Paige Strong M.D.
ADDRESS (Street, city or town, state): Grantsville, Md.
DATE SIGNED: 3/2/60

PHYSICIAN'S NAME (Type): A. PAIGE STRONG

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3/4/60

22c. NAME OF CEMETERY OR CREMATORY: ACCIDENT

22d. LOCATION (City, town, or county) (State): ACCIDENT GARRETT Co, MD

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Don J Newman, GRANTSVILLE, MD

24a. REC'D BY REGISTRAR DATE: MAR 10 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Frana

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3334 — Reg. Dist. No. 03308

1. PLACE OF DEATH
a. COUNTY ~~Preston~~ Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE West Virginia b. COUNTY Preston
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rowlesburg 85x-3
d. STREET ADDRESS Wilson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Barbara Middle Dianne Last Lewis
4. DATE OF DEATH: Month March Day 29 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20, 1954
9. AGE (In years last birthday): 6 yrs.
IF UNDER 1 YEAR: Months 2 Days 29
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: Grade School
11. BIRTHPLACE (State or foreign country): Terra Alta, W.Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Harley Melvin Lewis
14. MOTHER'S MAIDEN NAME: Elouise Virginia Yonker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Elouise V. Lewis, Rowlesburg, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lower Nephron Nephrosis; Anasarca; Hydrothorax; Ascites — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): 3rd & 4th degree burns (approx. 50% of body. 3 days
DUE TO (c):
916.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Atelectasis; terminal, due to aspiration of stomach cont
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Clothing caught fire from gas heating stove.
20c. TIME OF INJURY Hour 8:45 a.m. p.m. Month, Day, Year 3/27/60 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Rowlesburg, Preston, West Va.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H. Feister Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): James H. Feister Jr. M.D.
DATE SIGNED: March 29, 1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal & Burial
22b. DATE THEREOF: 4/2/60
22c. NAME OF CEMETERY OR CREMATORY: Terra Alta Cemetery
22d. LOCATION (City, town, or county) (State): Terra Alta, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Terra Alta, West Virginia. Md. F.D. No. A 7220
24a. REC'D BY REGISTRAR DATE APR 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kirana

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3335

CERTIFICATE OF DEATH

03309

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OAKLAND, MARYLAND
c. LENGTH OF STAY IN 1b: 2 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: GARRETT COUNTY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W. VA. — b. COUNTY: PRESTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STAR ROUTE TERRA ALTA
d. STREET ADDRESS: 85X-3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle DAVID — Last MESSENGER

4. DATE OF DEATH: Month MARCH — Day 6 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 15, 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Grocery
11. BIRTHPLACE (State or foreign country): TERRA ALTA, W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: SAMUEL MESSENGER
14. MOTHER'S MAIDEN NAME: BRAHAM, Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Charles W. Messenger, Terra Alta, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation - Cardiac Standstill — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Artery Disease — Unknown
DUE TO (c): Arteriosclerotic Cardio Vascular Disease — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia, Chronic
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 19 59, to March 6, 1960, that I last saw the deceased alive on March 6, 1960, and that death occurred at 3:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert W. Leighton M.D. — ADDRESS (Street, city or town, state): 77 Oak St, Oakland, Md. — DATE SIGNED: 6 Mar 60

PHYSICIAN'S NAME (Type): DR. HERBERT LEIGHTON — OAKLAND, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 9, 1960
22c. NAME OF CEMETERY OR CREMATORY: Maplewood Cemetery
22d. LOCATION (City, town, or county) (State): Elkins, West Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible], Terra Alta, West Virginia. — ADDRESS
Md. F.D. License A 7220
24a. REC'D BY REGISTRAR DATE: MAR 10 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3345

CERTIFICATE OF DEATH

Reg. Dist. No. 03310

1. PLACE OF DEATH
a. COUNTY GARRETT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE MD b. COUNTY GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XRURAL GRANTSVILLE
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last POLEMAN
4. DATE OF DEATH Month MAR. Day 2 Year 1960
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH MAR. 21 1869
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER-RETIRED
10b. KIND OF BUSINESS OR INDUSTRY OWN FARM
11. BIRTHPLACE (State or foreign country) GARRETT Co, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY POLEMAN
14. MOTHER'S MAIDEN NAME CHRISTINA CHRISTNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Mrs. Lawrance Poleman, RD, Salisbury Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 10 years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1956, to March 2, 1960, that I last saw the deceased alive on March 1, 1960, and that death occurred at 12:55 P.M., from the causes and an the date stated abave.

ACTUAL SIGNATURE A Paige Strong M.D. ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED 3/4/60

PHYSICIAN'S NAME (Type) A. Paige Strong

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 3/5/60
22c. NAME OF CEMETERY OR CREMATORY MT ZION
22d. LOCATION (City, town, or county) (State) STAR ROUTE, FROSTBURG, GARRETT Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE Don J Newman ADDRESS Grantsville, Md
24a. REC'D BY REGISTRAR DATE MAR 10 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3346 — Reg. Dist. No. 03311

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Swanton
c. LENGTH OF STAY IN 1b: 68 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5 Mi. S E Swanton

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland. b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Swanton
d. STREET ADDRESS: 5 Mi. S E Swanton
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Charles Middle Edward Last Rhodes
4. DATE OF DEATH: Month March Day 4, Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 13, 1891
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner Soft
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Jackson Rhodes
14. MOTHER'S MAIDEN NAME: Emily Bray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W W #1
16. SOCIAL SECURITY NO.: 213-18-2907
17. INFORMANT: Dorsey Paugh Address: R D #1 Swanton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation, acute — INTERVAL BETWEEN ONSET AND DEATH: hours
422.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis, moderate — years.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: James H. Feaster M.D.
EXAMINER'S NAME (Type): James H. Feaster Jr., M. D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 3-5-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/8/1960
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery
22d. LOCATION (City, town, or county) (State): Garrett County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. L. Leighton
ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR DATE: MAR 10 '60
24b. REGISTRAR'S SIGNATURE: Caitlyn S Krouse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar priar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3347 — Reg. Dist. No. 03312

1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Oakland,
c. LENGTH OF STAY IN 1b: 55 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): R. D. 2, near Red House

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Oakland,
d. STREET ADDRESS: R D #2, near Red House
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Harman — Middle: Casper — Last: Rolf
4. DATE OF DEATH: Month: March — Day: 2, — Year: 19 60
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 1, 1904
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Rolf
14. MOTHER'S MAIDEN NAME: Lydia Blamble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-24-2420
17. INFORMANT: Mrs. Harman Rolf — Address: R D 2, Oakland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fractured skull — INTERVAL BETWEEN ONSET AND DEATH: Immediate
912.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Farm tractor upset on slippery ground and pinned head on ground.
20c. TIME OF INJURY: Hour: 1 — A. M. ☒ P. M. ☐ — Month, Day, Year: 2-2-60
20d. INJURY OCCURRED: While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm
20f. (City or town) (State): Rural Oakland Garr. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: James H Feaster Jr. M.D.
EXAMINER'S NAME (Type): James H. Feaster Jr., M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 2-3-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/5/1960
22c. NAME OF CEMETERY OR CREMATORY: Red House Cemetery
22d. LOCATION (City, town, or county) (State): Garrett County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H. C. Leighton — ADDRESS: Oakland, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3348

CERTIFICATE OF DEATH

03313

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRIENDSVILLE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FRIENDSVILLE, MD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle EDWARD — Last SWAUGER

4. DATE OF DEATH: Month MAR. — Day 1 — Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 20, 1881

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER-RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): BITTINGER, GARRETT CO. MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL SWAUGER

14. MOTHER'S MAIDEN NAME: REBECCA HARMON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 220-03-3804

INFORMANT: Mrs. Edna Livingood — Address: Friendsville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIORESPIRATORY FAILURE
610 X
DUE TO (b): Hypostatic Pneumonitis — 6 WKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prostration due to Aging.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN, 1960, to Feb 29, 1960, that I last saw the deceased alive on Feb 29, 1960, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Pedro Rivera M.D.
ADDRESS (Street, city or town, state): Friendsville
DATE SIGNED: 3-2-60

PHYSICIAN'S NAME (Type): PEDRO RIVERA

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3/3/60
22c. NAME OF CEMETERY OR CREMATORY: GRANTSVILLE,
22d. LOCATION (City, town, or county) (State): GRANTSVILLE GARRETT CO. MD

23. FUNERAL DIRECTOR'S SIGNATURE: Don J. Bowman
ADDRESS: Grantsville, Md.

24a. REC'D BY REGISTRAR DATE: MAR 10 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3336

CERTIFICATE OF DEATH

03314

Reg. Dist. No.

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1. PLACE OF DEATH
a. COUNTY: Garrett — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cuppett Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegheny ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McCoole 01x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laura Middle: M. Last: Thompson

4. DATE OF DEATH: Month: March Day: 16, Year: 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/22/1872
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Hardy County, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Newhouse
14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ----
17. INFORMANT: Mr. Emory Thompson Address: McCoole, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Senile Changes
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 19 59, to March 16 1960, that I last saw the deceased alive on March 14, 1960, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E J Baumgartner M.D.
ADDRESS (Street, city or town, state): 235 Alder St Oakland Md
DATE SIGNED: 3/18/60
PHYSICIAN'S NAME (Type): E. J. BAUMGARDNER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 3/19/60
22c. NAME OF CEMETERY OR CREMATORY: Maple Hill Cemetery
22d. LOCATION (City, town, or county) (State): Petersburg, W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J. Blaine Shaffer Petersburg, W. Va.
24a. REC'D BY REGISTRAR DATE: APR 4 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03315

3349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: GARRETT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GRANTSVILLE
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE: MARYLAND — b. COUNTY: GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GRANTSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLIVE — Middle: MYRTLE ZELLER — Last:

4. DATE OF DEATH: Month: MAR. — Day: 10 — Year: 1960

5. SEX: FEMALE

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 30 1885

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): GROVE CITY, PA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN A. BARR

14. MOTHER'S MAIDEN NAME: FIRST NAME UNKNOWN WALLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Charles Zellers — Address: Grantsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
331X
DUE TO
(b): Cerebral arteriosclerosis — 5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1958 to March 10, 1960 that I last saw the deceased alive on March 9, 1960, and that death occurred at 3:00 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Paige Strong M.D. — ADDRESS (Street, city or town, state): Grantsville — DATE SIGNED: 3/11/60

PHYSICIAN'S NAME (Type): A PAIGE STRONG

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 3/12/60 — 22c. NAME OF CEMETERY OR CREMATORY: FROSTBURG MEMORIAL — 22d. LOCATION (City, town, or county) (State): FROSTBURG ALLEGANY MD

23. FUNERAL DIRECTOR'S SIGNATURE: Don J Bowman — ADDRESS: Grantsville, Md

24a. REC'D BY REGISTRAR DATE: MAR 14 '60

24b. REGISTRAR'S SIGNATURE: Cirilus S. Frantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58